DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 5 — 0 1 7

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10-1-95

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-299

7. FEDERAL BUDGET IMPACT:
a. FFY 96 $ 350,100.00 (Including I
b. FFY 97 $ 350,100.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A(1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Acute Hospital Inpatient Payment System

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required Under 45 CFR 204.1

12. SIGNATURE OF STATE AGENCY OFFICIAL: Bruce M. Bullen

13. TYPED NAME:
Bruce Bullen

14. TITLE:
Commissioner

15. DATE SUBMITTED:
12/29/95

16. RETURN TO:
Bridget Landers
Coordinator For State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 29, 1995

18. DATE APPROVED: JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 1995

20. SIGNATURE OF REGIONAL OFFICIAL: Ronald P. Preston for

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
Associate Regional Administrator, DMSO

23. REMARKS:

JUN 06 2001
OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services

I: OVERVIEW

On July 28, 1995, the Division of Medical Assistance of the Executive Office of Health and Human Services (hereafter referred to as "the Division") issued the Medicaid program's fifth Request for Application (RFA) to solicit applications from eligible, in-state acute hospitals which seek to participate as Medicaid providers of acute hospital services. The goal of the RFA was to enter into contracts with all eligible, acute hospitals in Massachusetts which accept the method of reimbursement set forth below as payment in full for providing Medicaid recipients with the same level of clinical services as is currently provided by those hospitals and their hospital-licensed health centers. In-state acute hospitals which: (1) operate under a hospital license issued by the Massachusetts Department of Public Health (DPH); (2) participate in the Medicare program; (3) have more than fifty percent (50%) of their beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric, pediatric intensive care, maternal (obstetrics) or neonatal intensive care beds, as determined by DPH; (4) currently utilize more than fifty (50%) of their beds as such, as determined by the Division are eligible to apply for a contract pursuant to the RFA.

An Applicant's Conference was held on August 9, 1995, at which time interested parties could ask questions to clarify any aspect of the methodology. Written questions and comments were accepted through August 18, 1995. The RFA and its methodology became effective October 1, 1995. All eligible acute hospitals are participating providers.

II: DEFINITIONS

Administrative Day (AD) - A day of inpatient hospitalization on which a recipient's care needs can be provided in a setting other than an acute inpatient hospital, and on which the recipient is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. See 130 CMR 415.415 and 415.416 attached as **Exhibit 1.**

Administrative Day Per Diem - An all-inclusive per diem payable to hospitals for administrative days.

Clinical Laboratory Service - Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

Community-Based Physician - Any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician.

Contract (Hospital Contract or Agreement) - The agreement executed between each selected hospital and the Division which incorporates all of the provisions of the RFA.

Contractor - Each hospital that is selected by the Division after submitting a satisfactory application in response to the RFA and that enters into a contract with the Division to meet the purposes specified in the RFA.

Department of Mental Health (DMH) Replacement Unit Services - Services provided in beds located on a staff-secure and locked psychiatric unit operated by a hospital, which is designated by DMH to provide acute inpatient services for certain recipients. Such services are reimbursed under a separate hospital contract with DMH and the Division.

Disabled Recipients - Recipients of the Medicaid program who are eligible under SSI and Medicaid Disability Assistance (categories of assistance 03 and 07).

Distinct Part Psychiatric Unit (DPU) - An acute hospital's psychiatric unit that meets all requirements of 42 C.F.R. Part 412.

Division - The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Division of Medical Assistance.

Gross Patient Service Revenue - The total dollar amount of a hospital's charges for services rendered in a fiscal year.

Health Maintenance Organization (HMO) - An entity approved by the Massachusetts Division of Insurance to operate as such.

Hospital - Any hospital licensed by the Massachusetts Department of Public Health as an acute hospital (and the teaching hospital of the University of Massachusetts Medical School), and which meets the eligibility criteria set forth in Section I of this State Plan.

Hospital-Based Entity - Any entity which contracts with a hospital to provide medical services to recipients on the same site as the hospital's inpatient facility.

Hospital-Based Physician - Any physicial, excluding interns, residents, fellows, and house officers, who contracts with a hospital to provide services to recipients on the same site as the hospital's inpatient facility.

Hospital-Specific Standard Payment Amount Per Discharge (SPAD) - An all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is complete reimbursement for an acute episode of illness, excluding the additional payment of Outliers, Transfer per Diems, and Administratively Necessary Days.

Inpatient Services - Services reimbursable by the Division pursuant to the RFA which are provided to recipients admitted as patients to a hospital.

Medicaid - The Medical Assistance Program administered by the Division to furnish and pay for medical services pursuant to the Massachusetts Medicaid Statute and Title XIX of the Social Security Act.

Medicaid MassHealth Managed Care - A comprehensive managed care program which consists of a Primary Care Clinician (PCC) Program and a Mental Health/Substance Abuse (MH/SA) Program. (Patients served through this program are referred to as recipients assigned to managed care.)

Merger - A reorganization of two or more acute hospitals into a single fiscal entity.

Outlier Day - Each day during which a recipient remains hospitalized at acute (non-psychiatric) status beyond twenty acute days during the same, single admission. AD days occurring within the period of hospitalization are not counted toward the outlier threshold as described in Section IV.2.A.8.

Pass-Through Costs - Organ acquisition and malpractice costs that are paid on a cost-reimbursement basis and are added to the hospital-specific standard payment amount.

Pediatric Specialty Hospital - An acute hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Pediatric Specialty Unit - A pediatric unit in an acute hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeds 0.20, unless located in a facility already designated as a specialty hospital.

Public Service Hospital - Any government-owned acute hospital which has a private sector payor mix that constitutes less than twenty-five percent (25%) of its gross patient service revenue (GPSR) and where uncompensated care comprises more than twenty percent (20%) of its GPSR.

Rate Year (RY) - The period beginning October 1 and ending September 30. RY96 begins October 1, 1995 and ends September 30, 1996.

Recipient - A person determined by the Division to be eligible for medical assistance under the Medicaid program.

Sole Community Hospital - Any acute hospital classified as a sole community hospital by the U.S. Health Care Financing Administration's Medicare regulations.

Specialty Hospital - Any acute hospital which limits admissions to children or to patients under active diagnosis and treatment of eyes, ears, nose, and throat, or diagnosis and treatment of cancer and which qualifies as exempt from the Medicare prospective payment system regulations.

Transfer Patient - Any patient who meets any of the following criteria: 1) transferred between acute hospitals; 2) transferred between a distinct part psychiatric unit and a medical/surgical unit in an acute hospital; 3) transferred between a bed in a DMH Replacement Unit in an acute

hospital and another bed in an acute hospital; 4) receiving substance abuse-related services whose status in managed care changes; 5) who becomes eligible for Medicaid after the date of admission and prior to the date of discharge; or 6) whose status in managed care changes while receiving mental health-related services.

***Upper Limit** - The term referring to the level below which it is determined that the hospital reimbursement methodology will result in payments for hospital services in the aggregate that are no more than the amount that would be paid under Medicare principles of reimbursement.*

***Usual and Customary Charges** - Routine fees hospitals charge for acute inpatient services rendered to patients regardless of payor source.*

III: NON-COVERED SERVICES

The Division will reimburse Medicaid participating hospitals at the rates established in the RFA for all acute inpatient services provided to Medicaid recipients except for the following:

A. Mental Health and Substance Abuse Services for Recipients Assigned to Managed Care

The Division's managed care Mental Health/Substance Abuse (MH/SA) provider has implemented selective networks of providers to deliver inpatient mental health and substance abuse services for Medicaid recipients assigned to managed care. For Medicaid managed care patients receiving such services, network hospitals shall be paid pursuant to contracts between the hospital and the MH/SA provider.

Non-network hospitals do not qualify for Medicaid reimbursement for managed care-participating patients seeking non-emergency inpatient psychiatric and substance abuse services. If a managed care Medicaid patient is admitted on an emergency basis by a non-network hospital, the hospital shall be paid by the MH/SA provider at the Medicaid transfer per diem rate capped at the per discharge amount for substance abuse-related admissions and at the Medicaid psychiatric per diem rate for psychiatric admissions.

B. Department of Mental Health (DMH) Replacement Unit Services

DMH Replacement Units are specially designated to contain beds in hospitals that provide high intensity services to seriously mentally ill patients who previously would have received services at a public mental health hospital prior to the closing of state mental health facilities. The services provided in DMH Replacement Units are of a higher clinical intensity than the services traditionally paid for by Medicaid in general hospitals, and provide for the treatment of acute mental illness or an acute episode of long-term serious mental illness. They are staffed and operated by hospitals pursuant to three-way contracts with DMH and the Division. Payments for DMH replacement unit services will be made pursuant to the hospital's three-way contract with DMH and the Division.

C. HMO Services

Hospitals providing services to Medicaid recipients enrolled in HMOs will be reimbursed by HMOs for those services. (See Section IV.2.A.11.)

Hospitals may not bill the Division, and the Division will not reimburse hospitals for services provided to Medicaid recipients enrolled in an HMO where such services are covered by the HMO's contract with the Division.

D. Air Ambulance Services

In order to receive reimbursement for air ambulance services, providers must have a separate contract with the Division for such services.

E. Hospital Services Reimbursed through Other Contracts or Regulations

The Commonwealth may institute special program initiatives other than those listed above which provide, through contract and/or regulation, alternative reimbursement methodologies for hospital services or certain hospital services. In such cases, payment for such services is made pursuant to the contract and/or regulations governing the special program initiative, and not through the RFA and resulting contract.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

IV: REIMBURSEMENT SYSTEM

1. DATA SOURCES

In the development of the base costs per discharge, the Division used its FY90 Medicaid paid claims file; the FY90 RSC-403 report, as submitted by each hospital to the Rate Setting Commission (RSC); and the FY90 Merged Casemix/Billing Tapes as accepted by RSC, as the primary sources of data to develop base operating costs. These data were supplemented by information from each hospital's FY90 year-end Maximum Allowable Cost (MAC) report and information from the intermediaries for the Medicare program, as needed. If a hospital's FY90 RSC-403 was not available, the hospital's FY89 RSC-403 was utilized. The "per review" version of the FY90 MAC report was used, if available. If it was not available, the FY90 "as filed" version was used.

The Division used the Medicaid paid claims file for dates of payment for the period June 1, 1994 through May 31, 1995 to develop the RY96 casemix index which adjusts operating costs. The Medicare cost reports (2552) for FY91 and FY92 for capital and the FY94 RSC 403 report (as filed) for malpractice, organ acquisition and direct medical education were used to develop rates of payment for capital costs, malpractice, organ acquisition, and direct medical education.

2. METHODOLOGY

A. Payment for Inpatient Services

1. Overview

Payments for inpatient services, other than for psychiatric services provided in distinct part psychiatric units, will consist of the sum of 1) a statewide average payment amount per discharge that is adjusted for wage area differences and the hospital-specific Medicaid casemix; 2) a per discharge, hospital-specific payment amount for hospital-specific expenses for malpractice and organ acquisition costs; 3) a per discharge, hospital-specific payment amount for direct medical education costs which includes a primary care training incentive and a specialty care reduction; and

4) a per discharge, hospital-specific payment amount for capital costs which is a blend of actual FY92 costs and a reasonable capital cost limit.

Each of these elements is described in Sections IV.2.A.2 through IV.2.A.5. The statewide average payment amount per discharge incorporates an efficiency standard.

Payment for psychiatric services provided in distinct part psychiatric units to Medicaid patients who are not served either through a contract between the Division and its MH/SA provider or in a DMH Replacement Unit shall be made through an all-inclusive regional weighted average per diem, updated for inflation and adjusted to reflect any reductions negotiated by the hospital and the Division's MH/SA provider (described in Section IV.2.A.7).

Payment for physician services rendered by hospital-based physicians will be made as described in Section IV.2.A.10.

2. The Hospital-Specific Standard Payment Amount Per Discharge (SPAD)

The first step in calculating the hospital-specific standard payment amount per discharge is the application of inflation, casemix and wage area to the statewide average payment amount per discharge.

The statewide average payment amount per discharge is based on the actual statewide costs of providing inpatient services to Medicaid recipients in FY90. The estimated actual costs of Medicaid patients in each hospital were determined using the Medicaid paid claims database for FY90, the FY90 RSC-403 and the FY90 MAC report. Cost and utilization data for the following were excluded in calculation of the statewide average payment amount per discharge: hospitals with unique circumstances, as set forth in Sections IV.B.1-IV.B.3; hospital units with unique circumstances, as set forth in Sections IV.B.2 and IV.B.5; and psychiatric units.

Estimated actual Medicaid costs were derived by a) multiplying Medicaid inpatient routine charges (net of AD routine charges) at each hospital by the hospital's cost-to-charge ratio for all routine services and b) adding this amount to the product of Medicaid inpatient ancillary charges (net of AD ancillary charges) at each hospital and the hospital's cost-to-charge ratio for all ancillary services.

Costs and charges associated with distinct part psychiatric units were excluded. Major moveable equipment depreciation and short term interest expenses were excluded as these expenses are treated as part of capital expenses. The cost center which is identified as the supervision component of physician compensation was included; professional services and other direct physician costs were excluded.

Malpractice costs, organ acquisition costs and direct medical education costs were excluded from the calculation of the statewide average payment amount. Capital costs were also excluded, as the reasonable level of payment for capital incorporates a separate efficiency standard.

Administrative Days used in the inpatient calculation were obtained from the FY90 Medicaid claims data file. If the hospital's claims data had zero AD days or the AD days were less than three (3%) percent of its total hospital days, the FY90 RSC 404-A fourth quarter reported AD days were used for such hospitals.

The estimated Medicaid costs for each hospital were then divided by the number of FY90 Medicaid discharges at the hospital to derive the estimated actual Medicaid costs per discharge.

The estimated actual Medicaid costs per discharge for each hospital were then divided by the hospital's Massachusetts-specific wage area index and by the hospital-specific FY90 Medicaid casemix index using the Version 8.0 New York Grouper and New York weights. (For the non-exempt Massachusetts hospitals in the areas designated by the Geographical Classification Review

Board of the Health Care Financing Administration, effective September 1, 1994, the average hourly wage of each area was calculated from audited FY91 Medicare 2552 Cost Reports. Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. For the calculation of the Springfield area index, the Baystate Medical Center's wages and hours were included). This step results in the calculation of the standardized Medicaid costs per discharge for each hospital.

The hospitals were then ranked from lowest to highest with respect to their standardized Medicaid costs per discharge; a cumulative frequency of Medicaid discharges for the hospitals was produced; and an efficiency standard was established as the weighted median cost per discharge. The efficiency standard was established as the cost per discharge corresponding to the discharge located at the seventy-fifth percentile; this means that 75% of the Medicaid caseload was treated in hospitals whose operating costs were recognized in full. The efficiency standard of $2,869.54 at the weighted seventy-fifth percentile is the highest Medicaid cost per discharge that will be recognized for any individual hospital in the computation of the statewide average payment amount.

The statewide average payment amount per discharge was then determined by multiplying a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by b) the outlier adjustment factor of ninety-seven percent (97%); by c) an inflation factor of 3.35% which reflects price change between RY92 and RY93; by d) an inflation factor of 3.01% which reflects price change between RY93 and RY94; by e) an inflation factor of 2.80% which reflects price change between RY94 and RY95; and by f) an inflation factor of 3.16% which reflects price change between RY95 and RY96. Each inflation factor is a blend of the HCFA market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the HCFA market basket to reflect conditions in the Massachusetts economy. The resulting

statewide average payment amount per discharge is $2,706.10.

The statewide average payment amount per discharge was then multiplied by the hospital's Medicaid casemix index (using version 12.0 of the New York Grouper and New York weights) based on Medicaid paid claims from June 1, 1994 to May 31, 1995 and the hospital's Massachusetts specific wage area index to derive the hospital-specific standard payment amount per discharge (SPAD). The wage area indexes were derived from audited FY92 Medicare Cost Reports (2552).

The outlier adjustment is used for the payment of outlier days as described in Section IV.2.A.8.

3. Calculation of the Pass-through Amount per Discharge

The inpatient portion of malpractice costs was derived from each hospital's FY94 RSC 403 report as filed. The inpatient portion of organ acquisition costs was derived from each hospital's FY94 RSC 403 Report as filed. The pass-through amount per discharge is the sum of the per discharge costs of malpractice and organ acquisition costs. In each case, the amount is calculated by dividing the hospital's inpatient portion of expenses by the number of total, non-psychiatric inpatient days and then multiplying the per diem costs by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. These preliminary numbers for malpractice and organ acquisition were then compared to each hospital's malpractice and organ acquisition payment amounts for RY95. The change in each payment amount was limited to 50% of the difference between each hospital's RY95 payment amount based on the Medicare Cost Report (2552) for 1993 and the initial RY96 amount using the RSC 403.

4. Direct Medical Education

The inpatient portion of direct medical education costs was derived from each hospital's FY94 RSC 403 report. For hospitals which began new primary care physician

training programs between October 1, 1994 and July 1, 1995, the Division shall recognize, on an interim basis, such new costs submitted by the hospital, as are determined to be reasonable by the Division, to be revised using costs reported in the as-filed FY95 RSC 403 Report. Such incremental costs for new programs shall be annualized. In each instance, the amount was calculated by dividing the hospital's inpatient portion of expenses by the number of total (non-psychiatric) inpatient days and then multiplying the per diem costs by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. The Division has incorporated an incentive in favor of primary care training which was factored into the recognized direct medical education costs by weighting costs in favor of primary care training. An incentive of 33% of the costs was added to the per discharge cost of primary care training; a reduction of 20% of the costs was subtracted from the per discharge costs of specialty care training. The number of primary care and specialty care trainees was derived from data provided to the Division by the hospitals. This preliminary number was then compared to each hospital's direct medical education payment amount for RY95. The change in each payment amount was limited to 50% of the difference between each hospital's RY95 payment amount based on the Medicare Cost Report (2552) for 1993 and the initial RY96 amount using the RSC 403.

Growth in direct medical education costs attributable to wage inflation will be subjected to a 10% annual limit. An audit may be performed by the Division to verify the appropriateness of reported teaching costs.

5. Capital Payment Amount per Discharge

The capital payment is a blend of actual capital costs, based on the FY92 Medicare cost report (2552), and a casemix-adjusted capital cost limit, based on the FY91 Medicare cost report (2552), updated for inflation, to be phased-in over five years.

For each hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, and long-term and short-term interest. Total capital costs are allocated to inpatient services through the square footage-based allocation formula used in the Medicare cost report (2552). The Medicare cost report is also used to identify capital allocated to distinct part psychiatric units and to subtract this amount from total inpatient capital in order to calculate the non-DPU capital cost per discharge.

The capital cost per discharge is calculated by dividing total inpatient capital costs (less that allocated to psychiatric DPU) by the hospital's total non-DPU days, and then multiplying by the hospital-specific non-DPU Medicaid average length of stay from casemix data.

The casemix-adjusted capital efficiency standard is determined by a) dividing each hospital's FY91 capital cost per discharge by its FY91 casemix index; b) sorting these adjusted costs in ascending order; and c) producing a cumulative frequency of discharges. The casemix-adjusted capital efficiency standard is established at the cost per discharge corresponding to the median discharge.

The capital efficiency standard was updated for inflation between RY93 and RY94 by a factor of 3.01%; for inflation between RY94 and RY95 by a factor of 2.80%; and for inflation between RY95 and RY96 by a factor of 1.80%. The RY96 capital update factor is taken from annual HCFA regulations used by HCFA to update the capital payments made by Medicare. The capital update factor is computed annually by HCFA and is calculated as

follows: HCFA estimates of inflation in depreciation, interest, and other capital related expenses, is multiplied by their respective weights, and summed. HCFA has estimated the value of this index in RY96 to be 1.8%, making the inflation factor of capital payments equal to 1.018. For RY96, the casemix-adjusted capital efficiency standard per discharge is $313.29.

The capital efficiency standard continues to be phased-in over a five-year period. In this fourth year of the phase-in, a hospital with capital costs below the median will retain 80% of the difference between its costs and the statewide standard; the capital payment for such a hospital will be the sum of the hospital's actual adjusted capital cost per discharge and 80% of the difference between the casemix-adjusted capital efficiency standard and the hospital's actual adjusted capital cost per discharge which is then multiplied by the hospital's casemix index to establish its per discharge capital payment amount. A hospital with capital costs above the median will be limited to the standard plus 20% of the difference between its costs and the statewide standard; the capital payment for such a hospital will be the sum of the casemix-adjusted capital efficiency standard and 20% of the difference between the casemix-adjusted capital efficiency standard and the hospital's actual adjusted capital cost per discharge which is then multiplied by the hospital's casemix index to establish the per discharge capital payment amount.

6. Maternity and Newborn Rates

Maternity cases in which delivery occurs will continue to be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn. Payment for all services (except physician services) provided in conjunction with such a maternity stay including, but not limited to, follow-up home visits provided as incentives for short delivery stays, are included in the SPAD amount. There will be no additional payments to the hospital or other entities (i.e. VNA's, home health agencies) for providing these services in collaboration with the hospital. Hospitals are required to apply any

and all maternity and newborn policies and programs equally to all patients, regardless of payor.

7. Payment for Psychiatric Services in Distinct Part Psychiatric Units and Department of Mental Health Replacement Units

a. Payment for Psychiatric Services in Distinct Part Units

Services provided to non-managed care Medicaid patients in distinct part psychiatric units shall be paid through an all-inclusive regional weighted average per diem. This payment mechanism does not apply to cases in which services are provided to Medicaid recipients in DMH Replacement Units; or to cases in which mental health or substance abuse service are provided to managed care Medicaid recipients. See Sections III.A and III.B.

The regions used to develop the all-inclusive regional weighted average per diem rates correspond to the six Health Services Areas established by the Massachusetts Department of Public Health (PL 93-641). These regional weighted average per diems were calculated by a) dividing each hospital's per discharge psychiatric rate established in the FY92 Medicaid RFA by the FY90 average length of stay pertaining to Medicaid psychiatric patients; b) multiplying the result for each hospital by the ratio of the hospital's Medicaid mental health days to the total Medicaid mental health days for the hospital's region; and c) summing the results for each region. The regional weighted average per diems were updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; 2.80% to reflect price changes between RY94 and RY95; and 3.16% to reflect price changes between RY95 and RY96.

For hospitals which are part of the Division's MH/SA provider network, the lower of the MH/SA

negotiated rate or the psychiatric per diem shall be the rate of payment in all cases where the psychiatric per diem established in the RFA applies.

b. Payment for Psychiatric Services in Department of Mental Health (DMH) Replacement Units

Year of Start-Up

Replacement unit services will be reimbursed through a prospective per diem payment which is based on the specific hospital's contracted allowable costs for replacement services and total projected days of replacement services.

Medicaid allowable costs will be based on a budget which represents a maximum level of reasonable and adequate reimbursable expenditures which will be recognized by the Medicaid program. Costs incurred in excess of this budget will not be reimbursed by Medicaid since each DMH Replacement Unit budget is based on an analysis which determined the reasonable and adequate costs which must be incurred in the efficient and economic provision of services. The hospital must prepare a detailed budget using its chart of accounts which can be summarized into the following cost categories:

A. Direct Costs
B. Physician Costs
C. Ancillary Costs
D. Major Moveable Equipment
E. Capital Costs
F. Indirect Costs

Direct Costs are the approved costs of staff salaries and fringe benefits, and supplies and expenses incurred in the unit. These include costs such as unit director, nursing staff, psychologists, social workers, therapists, mental health workers, and other staff directly assigned